

Group Name \_\_\_\_\_ Delta Group/Division Number \_\_\_\_\_

**A ENROLLEE** (Complete this section for new enrollment or change of status)

Name		Social Security Number		Date Employed		Action Requested		Please enroll me in the following:	
Last		(Member I.D. Number)		Month / Day / Year		<input type="checkbox"/> New enrollment <input type="checkbox"/> COBRA enrollment <input type="checkbox"/> Change in enrollment		<input type="checkbox"/> Delta Dental <input type="checkbox"/> Delta Vision	
First		Middle Initial		Year		<input type="checkbox"/> Reinstatement <input type="checkbox"/> Transfer <input type="checkbox"/> Rehire		<input type="checkbox"/> Delta Dental <input type="checkbox"/> Delta Vision	
Birthdate		Sex		Does your spouse have a dental plan?		Employee Classification			
Day / Month / Year		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who is covered: <input type="checkbox"/> yourself <input type="checkbox"/> spouse <input type="checkbox"/> dependent children		<input type="checkbox"/> Fulltime <input type="checkbox"/> Hourly <input type="checkbox"/> COBRA			
Do you have dependent children?		Marital Status		If Delta Dental, indicate group number: _____		<input type="checkbox"/> Certificated <input type="checkbox"/> Classified <input type="checkbox"/> Salaried			
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated							

Mailing Address \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_

City \_\_\_\_\_

**COBRA Enrollment**  
I understand that I may be required by the employer to pay for COBRA benefits

**Note:** If dependent is enrolling under own social security number, the original Member's social security number must be supplied.

Qualifying Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Benefits previously received under Social Security Number (Member I.D. Number) \_\_\_\_\_

**B Change to Existing Enrollment** (Complete all sections that apply)

Name change  Add new dependent  Delete dependent  Address change listed above

Reason for change \_\_\_\_\_

Effective date of change \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**C DEPENDENTS** (Complete for new enrollment or to add or delete dependents)

Spouse Name Last (if different)	First	Middle Initial	Add/Delete	Sex M F	Birthdate Month Day Year	Marriage/Divorce Date Month Day Year	Spouse's Social Security Number

**D Signature** (Form must be signed to be processed)

I understand there is no contribution required by me for coverage of myself or my dependents. (Exception — See COBRA enrollment) I agree to continue membership in this program during employment and while the program is in force and I agree to comply with the terms of the group contract.

Enrollee Signature \_\_\_\_\_ Date \_\_\_\_\_